

§ 414.1240

B will be adjusted using CMS' payment standardization methodology to ensure fair comparisons across geographic areas.

(2) The CMS-HCC model (and adjustments for ESRD status) is used to adjust standardized payments for the measures listed at paragraphs (a)(1) through (5) of this section.

(3) The beneficiary's age and severity of illness are used to adjust the Medicare Spending per Beneficiary measure as specified in paragraph (a)(6) of this section.

[78 FR 74821, Dec. 10, 2013]

§ 414.1240 Attribution for quality of care and cost measures.

(a) Beneficiaries are attributed to groups of physicians subject to the value-based payment modifier using a method generally consistent with the method of assignment of beneficiaries under § 425.402 of this chapter, for measures other than the Medicare Spending per Beneficiary measure.

(b) For the Medicare Spending per Beneficiary (MSPB) measure, an MSPB episode is attributed to the group of physicians subject to the value-based payment modifier whose eligible professionals submitted the plurality of claims (as measured by allowable charges) under the group's TIN for Medicare Part B services, rendered during an inpatient hospitalization that is an index admission for the MSPB measure during the applicable performance period described at § 414.1215.

[78 FR 74821, Dec. 10, 2013]

§ 414.1245 Scoring methods for the value-based payment modifier using the quality-tiering approach.

For each quality of care and cost measure, a standardized score is calculated for each group of physicians subject to the value-based payment modifier by dividing—

(a) The difference between their performance rate and the benchmark, by

(b) The measure's standard deviation.

§ 414.1250 Benchmarks for quality of care measures.

(a) The benchmark for quality of care measures reported through the PQRS using the claims, registries, EHR, or

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web interface is the national mean for that measure's performance rate (regardless of the reporting mechanism) during the year prior to the performance period. In calculating the national benchmark, individuals' and groups of physicians' performance rates are weighted by the number of beneficiaries used to calculate the individuals' or group of physician's performance rate.

(b) The benchmark for each quality of care measure reported through the PQRS using the administrative claims option is the national mean for that measure's performance rate during the year prior to the performance period.

§ 414.1255 Benchmarks for cost measures.

(a) For the CY 2015 payment adjustment period, the benchmark for each cost measure is the national mean of the performance rates calculated among all groups of physicians for which beneficiaries are attributed to the group of physicians that are subject to the value-based payment modifier. In calculating the national benchmark, groups of physicians' performance rates are weighted by the number of beneficiaries used to calculate the group of physician's performance rate.

(b) Beginning with the CY 2016 payment adjustment period, the cost measures of a group of physicians subject to the value-based payment modifier are adjusted to account for the group's specialty mix, by computing the weighted average of the national specialty-specific expected costs. Each national specialty-specific expected cost is weighted by the proportion of each specialty in the group, the number of eligible professionals of each specialty in the group, and the number of beneficiaries attributed to the group.

(c) The national specialty-specific expected costs referenced in paragraph (b) of this section are derived by calculating, for each specialty, the average cost of beneficiaries attributed to groups of physicians that include that specialty.

[78 FR 74821, Dec. 10, 2013]

§ 414.1260 Composite scores.

(a)(1) The standardized score for each quality of care measure is classified

into one of the following equally weighted domains to determine the quality composite:

- (i) Patient safety.
- (ii) Patient experience.
- (iii) Care coordination.
- (iv) Clinical care.
- (v) Population/community health.
- (vi) Efficiency.

(2) If a domain includes no measure or does not reach the minimum case size in §414.1265, the remaining domains are equally weighted to form the quality of care composite.

(b)(1) The standardized score for each cost measure is grouped into two separate and equally weighted domains to determine the cost composite:

(i) Total per capita costs for all attributed beneficiaries: Total per capita costs measure and Medicare Spending per Beneficiary measure; and

(ii) Total per capita costs for all attributed beneficiaries with specific conditions: Diabetes, coronary artery disease, chronic obstructive pulmonary disease, or heart failure (four measures).

(2) Measures within each domain are equally weighted.

[77 FR 69368, Nov. 16, 2012, as amended at 78 FR 74821, Dec. 10, 2013]

§414.1265 Reliability of measures.

To calculate a composite score for a quality or cost measure based on claims, a group of physicians subject to the value-based payment modifier must have 20 or more cases for that measure.

(a) In a performance period, if a group of physicians has fewer than 20 cases for a measure, that measure is excluded from its domain and the remaining measures in the domain are given equal weight.

(b) In a performance period, if a reliable quality of care composite or cost composite cannot be calculated, payments shall not be adjusted under the value-based payment modifier.

§414.1270 Determination and calculation of Value-Based Payment Modifier adjustments.

(a) For the CY 2015 payment adjustment period:

(1) *Downward payment adjustments.* A downward payment adjustment will be

applied to a group of physicians subject to the value-based payment modifier if—

(i) Such group neither self-nominates for the PQRS GPRO and reports at least one measure, nor elects the PQRS administrative claims option for CY 2013 as defined in §414.90(h).

(A) Such adjustment will be –1.0 percent.

(B) [Reserved]

(ii) Such group elects that its value-based payment modifier be calculated using a quality-tiering approach, and is determined to have poor performance (low quality and high costs; low quality and average costs; or average quality and high costs).

(A) Such adjustment will not exceed –1.0 percent as specified in §414.1275(c)(1).

(B) [Reserved]

(2) *No payment adjustments.* There will be no value-based payment modifier adjustment applied to a group of physicians subject to the value-based payment modifier if such group either:

(i) Self-nominates for the PQRS GPRO and reports at least one measure; or

(ii) Elects the PQRS administrative claims option for CY 2013 as defined in §414.90(h).

(3) *Upward payment adjustments.* If a group of physicians subject to the value-based payment modifier elects that the value-based payment modifier be calculated using a quality-tiering approach, upward payment adjustments are determined based on the projected aggregate amount of downward payment adjustments determined under paragraph (a)(1) of this section and applied as specified in §414.1275(c)(1).

(b) For the CY 2016 payment adjustment period:

(1) A downward payment adjustment of –2.0 percent will be applied to a group of physicians subject to the value-based payment modifier if, during the applicable performance period as defined in §414.1215, the following apply:

(i) Such group does not self-nominate for the PQRS GPRO and meet the criteria as a group to avoid the PQRS payment adjustment for CY 2016 as specified by CMS; and